The Hampden Hippocrat

NOVEMBER
1976

In His hand are all the corners of the Earth; and the strength of the hills is His also. The sea is His, and he made it; and His hands prepared the dryland. Let us come before His presence with Thanksgiving; and show ourselves glad in Him with Psalms.

Hampden District Medical Society

District Meeting

Tuesday, November 23, 1976

6:00 P.M. Business Meeting
7:00 P.M. Social Hour
7:30 P.M. Dinner

Menu:
French Onion Soup
French Tournedos, Bordelaise Sauce
Potato, Vegetable, Salad
Fruit Sherbert with Cherry Brandy Sauce

Hospitality Motor Inn
One Bright Meadow Blvd., Enfield, Conn.

Directions: First exit off of I-91 over the Massachusetts line—turn left and then right at the light.

Per person — $8.85

Speaker: Richard E. Palmer, M.D., President
American Medical Association

This meeting is a combined meeting of the Hampden District Medical Society, the Auxiliary to the Hampden District Medical Society and the Springfield Academy of Medicine.

Checks must be sent with reservation, $8.85 for one person or $17.70 for two persons. If paid at the door the cost will be $10.00 per person.

If you must cancel your dinner reservation, *PLEASE* call the office before noon on November 23, 1976.

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The official bulletin for The Hampden District of The Massachusetts Medical Society.
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THE HAMPDEN HIPPOCRAT is published monthly except for July and August.
The opinions expressed in this bulletin are those of the writers and do not reflect the official viewpoint of the Hampden District Medical Society unless so stated.
Communications pertaining to editorial content should be addressed to the Editor-in-Chief, W.E. Stevens, M.D., 24 Salem Road, Longmeadow, Mass. 01106
Business communications should be addressed to the Business Manager, J.B. Greenspan, M.D., 130 Maple Street, Springfield, Mass. 01103
Advertisements and Classified Ads should be directed to Mrs. Elsa Leahy, 3 Pearl Street, Westfield, Mass. 01085, as Assistant to the Business Manager.
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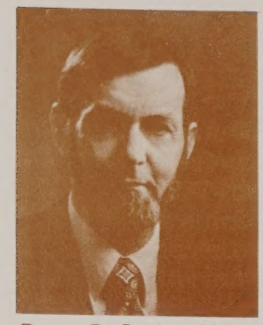

Bruce B. Stoler, M.D.

Your President's Page

The current status of physician's assistants and nurse-practitioners in Massachusetts was to have been covered in this issue of the Hampden Hippocrat. There is really no question that the physician will need additional hands to help him serve his patients if national health insurance becomes a reality. To "gear up" for this expected event, an increasing number of busy physicians have already chosen to take on responsibility for the clinical training of a PA or NP. You too may find that being a medical mentor to an eager mind gratifies your hidden desire to be a professor, the executive secretary can assist you in your quest.

In this issue you will find an up-to-date listing of the members of the H.D.M.S. in 23 separate columns corresponding to Hampden District's 23 councilors to the Massachusetts Medical Society. At my request, Dr. James Allan, Executive Councilor for Hampden District, has assigned a councilor to each member of the district. With this listing, each councilor has for the first time an assigned "constituency" to whom he is responsible. Responsible for keeping himself and them informed of the issues to be brought to the Council at its assembly each October, February and May. To do this, each councilor will try to meet with his constituency before and/or after each Council meeting for briefing purposes. And surely, as a concerned member of the society, you will wish to phone him to sound him out, to let him know that you're behind him or to give him "a piece of your mind" from time to time. Only through direct communication with your councilor can you expect fair representation of your views at the Council meetings.

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The listing of members can serve another important purpose as well. Check it over to see if the names of your closest colleagues are there. If not, take a few minutes to talk to them about joining the society and ask a member of the Membership Committee (whose names can be found elsewhere in this issue of the Hippocrat) to speak with them also. He can arrange for their attendance at a quarterly meeting of H.D.M.S. as guests of the society. A brief application form for new members also appears in this issue with information on local, state and national dues. A special effort is being made to recruit interns and residents.

This year the whole procedure of joining the society has been streamlined through the efforts of the Membership Committee and the effort has aroused national interest. The Public Affairs Division of the A.M.A., in a memo to the executive directors of all state and metropolitan county medical societies on October 8, singled out the H.D.M.S. Membership Committee as "an aggressive committee that could well serve as a model for any county society." Mrs. Purdy is already beginning to receive inquiries from other societies on this and sends to each a three-page compendium of the H.D.M.S. membership action program.

Challenging, restructuring and streamlining the organization and functions of your society has been a major emphasis of my administration to date. The results may not be known this year or next. But given the support of the membership, I believe that we will emerge as a stronger force in shaping the future of medical practice for all of us.

Bruce B. Stoler, M.D.
President HDMS, 1976-1977

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Medical School _____ Degree _____

Specialty _____ Teaching appointments _____

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Massachusetts Medical Society — Interns & Residents $15.00 per annum
Hampden District Medical Society — Regular Membership $92.00
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Any prospective member can meet the censors of the society and enjoy a free meal and see how it functions, at any quarterly meeting. Contact a member of the Membership Committee for details. See page 34 for their names.

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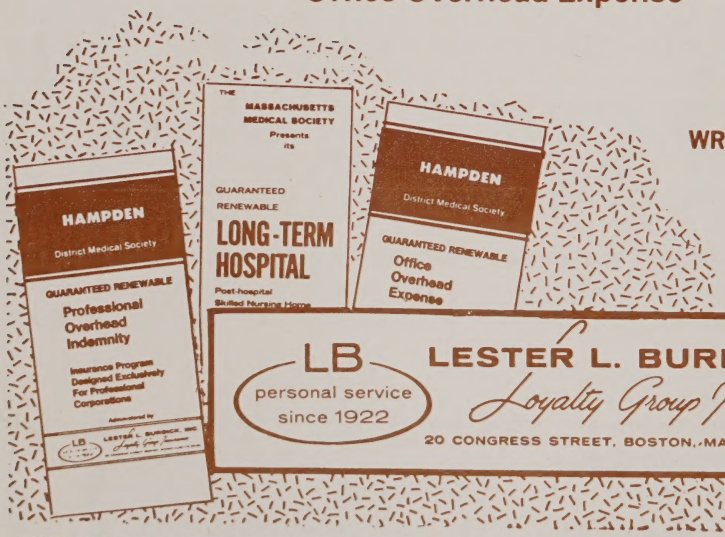

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Highlights of the Executive Committee Meeting

October 19, 1976

The Executive Committee met on Tuesday, October 19, 1976 in the Conference Room of the HDMS.

Present were Drs. Stoler, Walthall, Remsberg, Moore, Smith, Bloom, Magill, Cox, and Mrs. Purdy.

The minutes were accepted as written. Dr. Smith, Chairman of the Members Insurance Committee reviewed for the committee the recommendations he had presented to the MMS Council one week earlier. A substantial rise in premium for the Doctors' Group Blue Cross-Blue Shield is expected for next year.

Dr. Bloom, Chairman of the Public Relations Committee introduced Dr. John Fitzgibbon of Baystate Medical Center, Springfield Unit to the Executive Committee. Dr. Fitzgibbon is a nephrologist with some television experience. He proposed a medical TV program moderated by him at no expense to HDMS, to be presented "in cooperation with the HDMS."

The format would be similar to Boston TV 5's program "House Call" hosted by Dr. Johnson, consisting of an interview of a guest physician on a chosen subject followed by telephone calls form the audience, the entire program to be completed in a thirty minute period. A summary of this proposal was submitted by Dr. Fitzgibbon including his own qualifications. No medical advertising and no political references would be permitted. This program will probably not start for at least six months but a shorter version might be aired by spring. The committee approved this program, to be supervised on a continuing basis by the Public Relation Committee.

Dr. Bloom reported on the recent Medical-Media program at Wesson Hospital. He will coordinate further with editors of local papers. A Telephone and Collection program for Medical Assistants will be investigated and a date for presentation will be set. A statement of goals of the HDMS will be devised and presented by the PR committee and a report brought back to a future Executive Committee meeting.

Dr. Cox reported on progress of the HSA in relation to the HDMS and the other three districts in Region I. Cross-over points between HDMS and the PSRO are being investigated.

The AMA national announcement regarding the HDMS Membership Project was informational.

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Dr. Lovell's letter protesting smoking at district meetings was discussed in conjunction with Dr. Whiting's resolution. (see below)

It was voted to refer Dr. Whiting's "no smoking" resolution made at the September district meeting to the By-Laws Committee to develop this "no smoking" idea for committee meetings and district meetings, to be presented for vote at the next district meeting.

Dr. Tauber's resolution presented at the September District Meeting was reviewed. It will be referred to the MMS through our representative to the Tax Supported Medical Care Committee; Dr. Corsaro.

Mrs. Purdy reported on the meeting of the Council of New England State Medical Societies held in Boston, on October 2, 1976. The report was received by the Committee as informational with thanks to Mrs. Purdy.

Mrs. Purdy read a list of members on Probation by MMS for non-payment of dues. Mrs. Purdy will check the list and notify appointed Councilors of these names for personal contact.

The committee discussed whether there was a need for a "Publications Committee" to take over the publication of the Hampden Hippocrat, similar to the one the MMS has for the New England Journal of Medicine. A study committee was approved by the Executive Committee. Dr. Stoler appointed the following to be on this committee:

Howard N. Simpson, Chairman; John Remsberg, Walton E. Stevens, Bernard Bloom, Joseph Greenspan, and J. C. Ayres.

Dr. Moore spoke for the Scholarship Committee who had suggested that recipients of awards be charged 3% interest 5 years after graduation and a higher percentage after that. This will be discussed with the auditor and studied further by the Scholarship Committee before it is voted on by the Executive Committee.

Dr. Moore discussed making some formal recognition to Attorney Novak for the work he has done to establish the legality of the Dr. and Mrs. Max Millman Scholarship Fund. It was agreed that a letter of appreciation be sent to Attorney Novak, to be signed by the officials of the HDMS.

Dr. Griffin's request regarding labels on prescriptions will be referred to the Joint Conference Committee with Pharmacists and Dentists.

The next Executive Committee meeting will be held on Wednesday, November 17th instead of Tuesday, the 16th.

The meeting was adjourned at 10:05 P.M.

Submitted
Philip B. Stoddard, M.D.

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Telephone Manners

Have you ever been "turned off" by someone at the other end of the telephone line? Have you ever thought that with a little added effort either you or the other party could have had a pleasant conversation?

You may wonder what prompted us to write this article at this time. Communication has become so important in our rather busy lives that little annoyances may become very aggravating situations.

In recent calls to doctors' offices, our executive secretary has encountered rudeness and lack of cooperation in trying to contact members of our society. Our office personnel represents us in contact with our patients and outside callers. It is here that a first and possibly lasting impression of the doctor and his office are made.

Needless to say, the receptionist should be polite and courteous with whoever she is dealing. She represents the doctor when the telephone is answered. A pleasant voice, polite inquiries as to who is calling, and a readiness to cooperate in putting the caller in contact with the doctor will go a long way.

If the doctor is busy with a patient and can not, or does not wish to be disturbed at that time, then an appropriate response is given taking the caller's name and phone and offering to have the doctor call back as soon as he is free. She should then be sure the doctor gets the message without undue delay, especially if the call is said to be urgent. Messages received at the end of the day, when the party is no longer available (or has given up hope of a return call) are really not serving their purpose. Be sure that the message is received and note made of the call, so that the calling party does not feel neglected.

Good telephone manners will go a long way in making everybody's job easier and smoother. Remember that, "Kindness is the oil that takes the friction out of life."

Vivian Purdy, Executive Secretary
and Bernard Bloom, M.D.
P.R. Councilor

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The Page of the Auxiliary to the HDMS

The White Cap held November 6 was attended by over 250 persons. The food was delicious. The music was terrific. The raffle was fun. The scholarship coffers are fuller. Thank you Elsie Caldorola for making this all possible.

November 16 is A&P donation day for *our* auxiliary. If you need a shoppers' card call Pat Nenninger at 567-1913.

Mrs. Harvey Grant is busy with plans for the Holiday Tea on December 7. Invitations will be sent shortly. Plan to do some Christmas shopping that day at the AMA-ERF table. Mrs. Bruce Haskin promises us a lovely selection of items in all price ranges.

Mrs. Robert Bye and her committee are busy meeting and greeting new medical families in the district. If you know of a new family please contact Cynthia at 567-8562.

Mrs. Anthony Lovell, Health Career Chairwoman, reports she has been in touch with local secondary schools concerning health career films that are available. Films requested are being sent.

Mrs. Robert H. Nenninger
(Patricia)

APPLICATION FOR MEMBERSHIP
Auxiliary to the Hampden District Medical Society

Qualifications for Membership: A person shall be the spouse of a physician or medical student who qualifies and who has applied for Hampden District Medical Society membership or the widow or widower of a physician who qualified for membership at the time of death, provided that person has not remarried outside the profession.

Name _____ First name _____

Address _____

City _____ ZIP _____ Telephone # _____

The society hopes each member over the years will serve in some capacity. Please check an interested committee.

Health Education ____ Mental Health ____ Program ____ Health Careers ____
Legislation _____ Scholarship _____ Health Careers Fund _____
Historian _____ AMAERF _____ Publicity _____ Medical Library _____
Membership Welcome Wagon _____

Send form to: Mrs. Robert Bye (Cynthia)
170 Overbrook Road
Longmeadow, Ma. 01106

Views of a Hospital Administrator

By
Sister Catherine Laboure
Mercy Hospital
Springfield, Massachusetts

Problems and issues in the health world are taking on political, social, moral, and economic connotations as never before. The questions being posed and the solutions being offered leave us with a great sense of uneasiness. Three criteria often applied to the solutions are that they must be needed, doable, and affordable. The emphasis appears today to be on affordable.

With cost in mind, there is some movement in our country among government and various other groups associated with health care to reassess the policy put forth a few years ago that health care was the right of every person in the country. This right would then read *a right to access* to quality health care at reasonable cost. There is a very subtle difference between the right to health care and the right to access to health care.

We, as a people, have been encouraged in every way to believe that whatever our health needs are, they can be met. Now, without directly telling us so, rules and regulations are being written and promulgated that will make it impossible for the health care field to meet these demands. At the same time that this is being done, programs are being developed and implemented that will commit health care agencies to greater expenditures in order to provide new services. As a nation, we have become accustomed to false promises, and the promise of health care for all would appear to be a false promise unless something changes in the way all of us, government included, work together to develop new goals for health care in this country.

What is the level of health care that we, as a nation, are prepared to provide? Can every person have access to the most sophisticated procedures? Does the projected life span or productivity of a person become a deciding factor? These are just two of many questions that are being asked today. There are many groups in our country at this moment studying the answers to these questions. Our concern should be that they are not decided just on the question of whether or not a thing is affordable. It has been decided by *someone* that we have reached the limit of our gross national product that we can put into health care. I'm not sure that this is a fact. You and I have read arguments for and against this stand. It is up to us to force a realistic reassessment of this decision.

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Predicting the future of health services in the United States can be an interesting mental exercise. Efforts to take huge steps into the future always seem to be limited by strings attached to our pragmatic past. The predictions will inevitably bring us to a redefinition of the country's philosophy of health care and to a reevaluation of its commitment to health care. Any attempt to predict with accuracy what the philosophy and commitment to health care will be in the future is likely to yield results that are presumptuous, for many of the health care issues lack focus and are intricately linked, and piecemeal discussion by its very nature is deficient. Therefore, it seems unreasonable to believe that we can prescribe entirely new models of delivering health services that will replace the existing systems. If that is so, then evolution rather than revolution will be the means for change in health care. The evolutionary process has begun. There are hundreds of people within our area who spend hours as volunteers working on what the future of health care should be in this area. They are encouraged and supported by our federal government in its search for answers to the questions that are being raised. I believe that there are more questions than those that are being asked. I do not believe that the answers are easy and simple. I believe that we have to move forward courageously into the future in the quest for alternatives.

Sister Catherine Laboure

Medical School Scholarship Recipients for 1976

Tanya J. Korkosz
Tufts University Medical School
Boston, Ma.

Jeffrey R. Cossin
University of Rochester
School of Medicine
Rochester, N.Y.

Richard P. Morin
The Medical College of Wisconsin
Milwaukee, Wisconsin

Robert J. Belisle
Kansas City College of
Osteopathic Medicine
Kansas City, Missouri

Catherine M. Shaer
University of Texas Medical School
San Antonio, Texas

Alphonse F. Calvanese
Tufts University Medical School
Boston, Ma.

Christopher J. Schmidt
University of Massachusetts
Medical School
Worcester, Ma.

Mary A. Dougal
Stritch School of Medicine
Loyola University
Maywood, Illinois

Christopher J. Corey
Georgetown University Medical
School
Washington, D.C.

Ronald C. Holt
Faculte Libre de Medecine de
L'Universite College
Lille, France

John J. Moynihan
Georgetown University School
of Medicine
Washington, D.C.

William B. Coen, M.D.
Chairperson
Scholarship Committee

To The Editor:

I would like to support Dr. Whiting's proposal to ban cigarette smoking at the meetings of the Hampden District Medical Society.

Following the last meeting, even though only a few members chose to smoke, my wife commented upon the stench of cigarette smoke contaminating my suit when I returned to my home that evening. From a professional point of view, I think that it is also very important that we ban smoking so that the Medical Society is consistent in its stand.

I have recently been asked by Dr. Stoler to attend the hearings relating to air pollution on behalf of the Public Health Committee of our medical society. I think that it is very important that we maintain a uniform standard with respect to stressing the hazards of cigarette smoking. Even the smoking of low tar and nicotine cigarettes does not protect an individual from the damage to vascular endothelium from carbon monoxide which is very definitely present in cigarette smoke. It is the carbon monoxide that reduces the anginal threshold and promotes atherosclerosis experimentally.

Sincerely yours,
Anthony P. Lovell, M.D.

P.S. We support Dr. Lovell's position on this matter.

Howard M. Ledewitz, M.D.
Stephen M. Wittenberg, M.D.

Poet's Corner! Addenum to the Minutes

(At the September meeting of the HDMS Dr. Lewis W. Whiting presented a resolution to ban smoking at Society meetings.)

Presented at the meeting was
A formal resolution
To demonstrate what smoking does
To maximize pollution.

A cry went up, in fact a bleat,
Adherents of tobacco
All mumbled, grumbled, stamped
their feet
And shouted to the echo.

Should doctors some example set
To tell the public who may
Light up cigar or cigarette,
Then cry *Defense de fumer?*

The members, peering through the
smoke,
On smokers showed their pity.
Courageously they rose and
spoke—
Referred it to committee.

Lew Whiting, bless his honest soul,
Had tried to give the answer.
That's how it is, from Pole to Pole,
From Capricorn to Cancer.

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Group Representation in the Medical Profession

by Neil Sivek

I. Introduction

The medical profession is unlike any other group of workers in America today. They do not have a union, per se, to protect their interests and act collectively on their behalf. Instead, doctors are represented by a hierarchy of professional medical societies which attempt to fill the void left by the absence of a union structure. This paper examines these professional organizations, their functions and effectiveness, and evaluates them relative to a standard trade or craft union. The system is portrayed from the national level down through the state and local levels using Massachusetts and Hampden County as case studies. Because such information is not readily available in published form, the majority of research was done by interviewing several people who hold positions relative to the topic.

II. The Need for a Society in Today's Society

With the great advances in medical technology that have taken place in recent years, the American public has come to expect one hundred percent successful results in health care today. If the cure is less than completely satisfying to the patient, no matter who is at fault, it is the doctor that is blamed and often sued. For example, a patient in the hospital for ankle surgery contracted tuberculosis from the patient in the next bed. The doctor was unaware of the second patient's condition because the hospital had not informed him. Yet, he is currently under suit because the patient feels it is his fault and because the doctor is the one who has the personal contact with the patient. It is relief from this type of situation that physicians are seeking from their professional societies. While this is almost certainly not the reason groups such as the American Medical Association were formed, it is certainly a major factor in their continued existance today. Whether it is the AMA or some other group, doctors feel they do need some protection against the pressures brought to bear by the public.

III. The Structure of the Medical Societies

Similar to trade unions, the medical societies operate on three levels: federal (AMA), state Massachusetts Medical Society: MMS), and local (Hampden District Medical Society: HDMS). The general purpose of all three levels, as expressed in the by-laws of the local, is to "elevate standards of medical practice and to promote and protect the health of the public." Membership in the national organization is optional for all, but those who wish to join the local must also join the state group. In the state of Massachusetts, there is no requirement to join the MMS or the HDMS. These two groups are basically independent of each other, except for the fact that the local must conform to the standards set by the state association and the state council is filled by representatives from each of the districts.

THE LOCAL: In order to join the HDMS, a doctor must be licensed to practice medicine in the state, have

his practice established in Hampden County, and pass review by the society's Board of Censors. Once he becomes a member, for which there is no initiation fee, a doctor is required to pay only the annual local dues of ninety two dollars. The main function of the local society is the surveillence of the "grass roots" (this term was used by several of the interview subjects) aspects of practicing medicine. It is governed by an executive board of four elected officers and a rotating executive committee of six elected doctors, two of which are replaced each year. There are over twelve committees designed to deal with local problems that occur. All are chaired and manned voluntarily by two to ten rank and file members each. These committees, which include public relations, peer review, mediation, political action, medico-legal, public health, Blue Cross/Blue Shield, by-laws, and religious, also have non-physician members pertinent to their purpose. For instance, there are four lawyers on the legal committee and clergymen on the religious committee.

Some of the more prominent functions of these committees bear further examination. The mediation committee exists to provide a grievance procedure for patients and doctors who wish to lodge complaints against other doctors. Such matters are often about unethical practices i.e. advertising or unfair fees. The decision of the mediators is in no way binding, but is usually fair enough to be accepted by both parties. Should there be no satisfaction, either party can proceed up the hierarchy to the State Committee of Ethics and Discipline or the Board of Registration of Medicine and Discipline. Neither of these two boards can issue binding decisions either, but the latter is empowered to revoke a physician's license. The only compulsory recourse that can be sought is legal action, which is not necessary in most of the cases. Expulsion from medical societies is the only power given to the societies. The members prefer that all other decisions are made by someone with no prior bias. The legislative committee serves mainly to act as a liason between the membership and the vast number of bills coming through the federal and state Senates of which the physicians must be kept aware. The majority of committees act mainly on request, rather than with ongoing functions. While they usually do come up with good proposals, their efforts are often wasted because the locals are rarely heard from unless the AMA or MMS comes to them first.

The society holds four membership meetings each year, in addition to the monthly meetings of its executive committee. About one-fourth of the members usually attend those meetings. The informa-

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tion obtained at the meetings and the HDMS Newsletter is generally material not covered through the state function because it is not relevant to the entire state. The monthly newsletter is short and restricted to notices of meetings, messages from officers, letters, editorials, and some current developments on issues that are of interest to the medical profession.

THE STATE: Most states each have one medical society, but some of the larger ones have two. They are comparable to national unions. The MMS unifies the twenty one districts in Massachusetts by having each district elect one man for every twenty five members to represent it on the governing body, the MMS council. Like national unions, the state body is the main force in handling matters of widespread interest such as welfare payments and Blue Cross/Blue Shield. The AMA intervenes only when the state is dealing with an issue of national concern. The annual MMS dues of one hundred ten dollars helps to pay the salaries of the full-time lobbyists that the group has to represent its interests in the state legislature. It attempts to establish and maintain standards for its members which uphold the dignity of the profession by bringing together the many different types of doctors, in regard to both background and specialty, and to direct their efforts in the same direction. The MMS and the legislature often work together for the doctors' benefit. The most recent examples of this are the formation of a joint underwriters association to help handle the increasing cost of malpractice insurance and the nation's first tribunal, composed of a doctor, a lawyer, and a judge, for preliminary review of malpractice suits. The MMS also serves as a stepping stone by assuming responsibilities too great for the local level and not of sufficient magnitude for the AMA.

Its monthly newsletter is more intricate than that of the HDMS. It features newspaper-type articles of widespread interest, such as AMA policies and state budget cuts, notices of statewide events, and issues pertaining only to members of the medical profession, like the provider-owned insurance company. The MMS also is responsible for the New England Journal of Medicine, a nationally acclaimed medical publication.

THE FEDERAL: Comparable to the AFL/CIO, the AMA maintains "jurisdiction" over the entire nation. This is not in the sense of its power to command, but in whom it serves. It represents the doctors legally, legislatively, and socially. The annual dues for AMA membership is two hundred fifty dollars and its function is basically the same as the MMS, but on a national level. The officers and ruling body, the House of Delegates, is made up of repre-

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sentatives elected by each state association, which is entitled to one vote for every 1500 AMA members in the state. The ultimate purpose in all AMA activities is to establish medical care and educational standards in cooperation with the general public and medical schools. Its most effective means of accomplishing this is through the lobbyist it has in Washington, D.C., who serves as the AMA's input mechanism for federal health legislation. So, by providing an outlet for physicians to express their views through representation, keeping its members aware of new developments (technical, as well as socio-economical), and its political influence, the AMA tries to exemplify the strength in numbers principle that the AFL/CIO is built upon. However, since the AMA prefers not to get involved with political affiliations, doctors that felt otherwise formed the American Medical Political Action Committee to voice their opinions on the subject. The group is independent of the AMA, but is a direct result of someone's efforts to remedy a situation he disagreed with.

IV. Effectiveness and Success of the Representation System

There is a great deal of criticism by the physicians that the present methods are useless because there appears to be no substantial return on the over three hundred fifty dollars that they are paying each year in dues for representation of their interests. While this may be a valid complaint to some extent, it is an exaggeration and the blame is partially misplaced. First of all, there is a great deal of apathy on the part of the membership. This is illustrated by the fact that many doctors don't even take the time to return the MMS questionnaires designed to solicit their opinions. The system is designed so that any doctor who is willing to put forth the effort can obtain some results. Unfortunately, the majority chose to be governed instead of helping to govern themselves for a multitude of personal reasons. Every once in a while, the doctors get excited about some issue, but interest usually dies before any significant action is taken.

Another complaint is that while the structure of the system is satisfactory, the people in charge are too old to be capable of handling the contemporary problems. Even though they are elected by the members, those who have served the most time in the system over the years are usually unchallenged for the higher offices. In effect, the hierarchy puts the people in office, so when they get there, they are behind the times and not truly

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representative of the majority of active practitioners. As an example, when the state passed the thirty percent cut in welfare payments to physicians, the medical societies did not publicly voice any objections on behalf of their members. Instead, they worked quietly with the legislature and left the doctors to individually write letters to the state. The cut was subsequently reduced to be a five month program. A second example is the lack of action by the AMA when an independent group created by federal law, the Physicians' Society Review Organization, was formed for peer review. It was too late to make it part of the AMA, as it should be. The obvious answer to this problem is that those who care enough to complain about the system should care enough to eliminate the apathy and get the younger doctors involved. This is a problem because a young doctor must spend a great deal of his time establishing a practice and can not afford the time it takes to be so involved. However, there is currently a new procedure in the AMA designed to reduce the emphasis on seniority and foster more dynamic, youthful leadership.

From a broader, social aspect, part of the blame lies with the public. Because they demand so much of the profession, the physicians feel a need to protect themselves from the public. Through the AMA, doctors are able to fight to retain their freedom to practice medicine in what they believe is the best manner for everyone concerned. A primary case is the Medicare/Medicaid program. When it was first proposed, the AMA opposed it, saying that it would cost much more than was being budgeted for it. Even in spite of the fact that the AMA proved to be correct, the public and some more liberal doctors considered the association a "bad guy" group because it opposed something the public wanted. Along this same line, physicians are trained in their profession to react to given situations. They are not innovators and in this age of tremendous progress, people are not content with simply maintaining the status quo. Hence, the AMA is frowned upon, which makes it that much more difficult for it to operate effectively.

From a political standpoint, there is a conflict of interests between the

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medical and legal professions. This is borne out by a paradox of values. Lawyers get up to seventy-five percent of the awards in malpractice suits for their legal services. They are also the main supply of future politicians and therefore, lawmakers. Why should they change the laws that enable them to live so well if there is no pressure from the doctors to do so? The politicians are concerned with winning votes, so they do what the public wants. This means progressive, innovative legislation. As already noted, the medical profession does not exist for this purpose. Developing new techniques is the job of medical researchers, not practicing physicians. The overall effectiveness of the AMA may be reduced because it must be the middle-man between the doctors and lawyers. It is currently on a trend to improve the interaction between these two factions by trying to see that each one's interests are served, but not at the expense of the other. As the AMA is the only group operating in such a capacity, this roll must be accepted in spite of its weaknesses and improved upon. It will serve no purpose for a physician to ignore the AMA just because he does not agree with some of its policies and opinions.

The physician with a skeptical opinion of the AMA sees only two real benefits derived from being a member: group policy discounts for life insurance and Blue Cross/Blue Shield coverage and a source of information on medical developments. The advocates of the system hold that the true benefits can not be measured in monetary terms, as the work of a trade union can be seen in wage hikes and improved working conditions. Instead, the dues money is used to foster high standards of medical care and education to which the members of the profession have committed themselves.

V. A Related Concern: Hospitals

The structure of hospital representation is similar to that of physician representation. The American Hospital Association (AHA) has headquarters in both Chicago and Washington, D.C., where it pays a lobbyist to represent its interests in Congress. The main driving force is the state organization. The Massachusetts Hospital Association, which operates out of Boston, has informally divided the state into seven regions according to location and basic needs. Membership, which is open to all hospitals in the state, in any one level of the system requires membership in all higher levels and dues for each are based on the number of beds in each hospital. The state association sends its spokesman into the state legislature while the local regions rely on direct contact with the state representatives from their individual areas. As in the medical societies, the officers are elected by the members to afford equal represen-

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tation with respect to size and geographical make-up. However, those elected are usually those who have worked their way up the hierarchy and do not always mirror the opinion of the majority.

An example of the work of the state association is the bill now pending to give the state control of major hospital costs. The MHA has issued a uniform response against the proposal on behalf of its members and is directing a campaign for the hospitals to protest it on an individual basis as well. It is also meeting with the politicians to review the entire situation. The MHA also issues weekly reports to all of its members to keep them abreast of the latest legal and technical developments in the hospital field. The MHA is not a policing unit and does not make value judgements because there are state agencies that handle such matters.

The AHA is a much more formalized organization. It publishes the professional magazine and trade journals in addition to its weekly bulletin from Chicago and newsletter from the Capitol. Its title, Washington Developments, is self-explanatory.

VI. An Alternative System: Unionization

There appears to be some desire to change the present system of representation. One alternative is to unionize the medical profession. The established physicians are generally opposed to unionization because they feel it is very unprofessional and would have a dehumanizing effect on the field. In addition, the present system does not readily invite corruption because there are no pension funds, strike funds, or other kittys beside the treasury. The AMA opposes unionization because of unions' contrary nature to individualism, which it feels would undermine the doctor-patient relationship. Also, a union has narrower, more economically oriented goals than the professional society. The House of Delegates issued a statement which said that the AMA can do for its members anything lawful that a union can do, but without making the doctors a "class of super technicians within the framework of organized labor." (Monthly Labor Review; June 1975)

The pro-union view contends that since the AMA rejects the concept of collective bargaining, doctors need some group to protect both their interests and their patients' and to deal with the socio-economic aspects of their profession. The only unanimous opinion is that doctors should have the right to strike against the bureaucratic aspects of the medical profession. The doctors say that they would never withhold services from a patient. Instead, they would simply eliminate all of the paperwork and third party involvement not vital to treatment in order to maintain the autonomy of the profession. As a result, there are now two national physicians unions, the National Conference of Physicians Unions (AFL/CIO affiliated) and the American Federation of Physicians and Dentists (independent), as well as the several local collective bargaining groups that exist. All together there are 16,000

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dues paying members in these unions, none of which have any great impact or influence in the government or with the public today.

The majority of effective unionization in the medical field has taken place with the interns and residents in hospitals. Originally, these people were considered students getting an education and therefore not entitled to rights such as collective bargaining. In 1973, Jay Harness, a fourth year resident at the University of Michigan Medical Center, won recognition for his Interns and Residents Association as a collective bargaining agent. Then in 1974, the Physicians House-staff Association was founded with the intent of obtaining written contract for its 18,000 members. Numerous petitions to the National Labor Relations Board finally won the right to form bargaining units and be represented by a labor union in accordance with the Wagner Act of 1935. The American Association of Medical Colleges lost the argument that interns are students because their only difference from more conventional employees was ruled to be in their title.

The first strike in the medical profession came on march 17, 1975 in New York City when approximately 3000 interns and residents of 21 metropolitan hospitals set up picket lines in protest of their working conditions. There was also a salary dispute, but that was settled before the strike as the interns agreed to an 8% increase instead of their initial 11% demand. The main issue was the 100 hour work week with up to 48 hours in a row that these people had to put in. They complained that it resulted in great fatigue and therefore errors in the medical treatment of their patients. While this appears to be a very noble cause, it is not as entirely as altruistic as it seems. No one likes to stay up for two days without rest and it is not surprising to see them try to eliminate such conditions. The union, The Committee of Interns and Residents, saw to it that the patients did not suffer during the strike. They gave the hospitals ample notice so that the senior staff could rearrange their schedules to pick up the slack. Also, strikers often left the picket lines to attend to their patients, knowing that if they did not do it, it might not get done. The AMA endorsed the strikers' demand for shorter hours to provide better medical treatment. The hospitals maintained that the strikers were violating their Hippocratic Oath and that, as students, their education was not a matter for negotiation. After four days, an agreement was reached. The work week would be limited to eighty hours with a maximum of fifteen in a row and only one out of every three night shifts. In addition, each hospital

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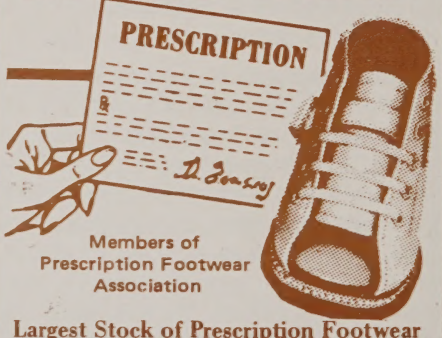

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consented to work out individual problems through committees of administrators, interns, and residents. These issues concerned the doctors having to do what they felt were the jobs of nurses, aides and orderlies. When all of the questions pertaining to correct bargaining units for all of the hospital workers get answered, a whole new wave of collective bargaining will become prominent in America.

VII. Summary and Conclusions

As it exists today, the system of representation in the medical field is in need of some revision. Doctors are constantly in the public eye and subjected to unending criticism. Hence, they are entitled to protection similar to that afforded most other workers in America. The AMA, MMS, and HDMS operate on three levels similar to the labor union structure of the AFL/CIO, nationals, and locals. The AMA, governed by an elected body, serves its members across the nation and represents them in Washington, D.C. It does not have the power to command, only to establish and maintain certain standards. The MMS is the main driving force in the system because each state has its own rules concerning the medical profession which can not be handled on a national level. It is structured like the AMA, but on a smaller scale. The HDMS, like local unions, handles all of the "grass roots" aspects of the profession such as peer review and mediation with the public, which is different for each region.

The major complaints by the doctors are that they are not truly represented and that these societies do very little for them. The solution lies with the younger physicians. They must get more involved with the structure rather than just complaining about the job the older doctors are doing. Unionization is not the answer because physicians are professional men, not blue collar workers, and the two groups can not be handled the same way. The doctors are independent businessmen who are not looking to sign themselves to an en masse group. Also, older doctors are concerned mainly with the laws that affect them, while the younger doctors and interns are more concerned with the working conditions in hospitals. Unions may be the answer for the latter group, but for those with established practices the solution is increased involvement and making themselves heard when they care enough about an issue.

EDITOR'S NOTE:
Personal Data on Author

NEIL SIVEK—Age: 20 years old. Home: 102 Blueberry Hill Road, Longmeadow, Mass.; Education: Third year management major at the Wharton School of the University of Pennsylvania. School address: 3700 Spruce St., Philadelphia, PA.

The thoughts, ideas and views expressed herein are entirely Mr. Sivek's. They in no way reflect for good or bad the Societies' or Hippocrat's views. These views of Mr. Sivek reveal what one "outsider" saw and wrote about organized American medicine.

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Obituaries in HDMS

The Society is saddened to report the deaths within the past six months of seven of its members. They will indeed be sorely missed by their many friends and professional colleagues in this area.

John A. Huffmire, M.D.

Died April 30, 1976 in the Noble Hospital, Westfield, after a brief illness at the age of 75. Dr. Huffmire was a graduate of Union College and Middlesex Medical School (1924). He interned at St. Francis Hospital, Jersey City, New Jersey and did his residency in surgery at St. Joseph Hospital, Patterson, New Jersey. He had been a surgeon for the New York Central Railroad, Boston and Albany Division. He had been a staff physician at the Noble Hospital since 1927 and had served formerly as Chief of Surgery at that institution. He was also Chief of Staff at the Noble Hospital from 1965 through 1970. He served as Medical Examiner for the 2nd district from 1930 until 1974. In addition to his medical responsibilities, Dr. Hoffmire had been active in business and community affairs. Contributions may be made to the Arenstam-Huffmire Scholarship Fund or to the Noble Hospital Building Fund.

Joseph Schiff, M.D.

Died June 8, 1976 at age 69 in the Baystate Medical Center. He was a graduate of St. John's College of Annapolis and the University of Maryland School of Medicine and Surgery (1933). He interned at the Wesson Memorial Hospital and also served his residency there with rotations through the Shriners Hospital for Crippled Children and the former Springfield Isolation Hospital. He was in general practice and served on the staffs of the Wesson Memorial Hospital, Wesson Maternity Hospital, Mercy Hospital, Northampton State Hospital, and Veterans Administration Hospital, Northampton. In 1971 he received a gold plaque from members of the staff at Wesson Memorial Hospital for his professional and personal service. He was former Physician for the Springfield school system. He was active in Longmeadow community affairs serving on the Longmeadow Disaster Team, Jewish Home for the Aged, United Fund and United Jewish Appeals. Contributions may be made to the Dr. Joseph Schiff Scholarship Fund at the Hampden District Medical Society or to the memorial fund of the Wesson Hospital Unit of the Baystate Medical Center.

John T. Branciforte, M.D.

Died October 17, 1976 at age 60 in the Baystate Medical Center, Springfield Unit after a brief illness. He was a graduate of the University of Alabama and Middlesex Medical School (1943). He interned at Wyckoff Heights Hospital, Brooklyn and served as resident at Doctors Hospital, New York City. He was engaged in general practice and served as Staff Physician at the Wing Memorial Hospital for 30 years and Ludlow Hospital for 8 years. He was former School Physician for the Palmer school system and was a former president of the medical staff at Wing Memorial Hospital.

Eugene George Boss, M.D.

Died July 11, 1976 at age 77 in the Baystate Medical Center. He was a graduate of Georgetown University and Georgetown University Medical School (1923). He served his internship at the St. Francis Hospital, Hartford, Connecticut, and the U.S. Veterans Hospital, New Haven, Connecticut. His residency training was at the Boston City Hospital. He was a fellow and diplomat of the American Boards of Ophthamology (1932) and the American Board of Otolaryngology (1939). He was engaged in the practice of ophthalmology in Springfield for many years and served on the staffs of the Mercy, Wesson Memorial and Springfield Hospitals. He was elected a member of the American College of Surgeons (1933). He was awarded the Golden Certificate of the Hampden District Medical Society for 50 years of medical practice in 1976. In addition to his professional activities and association memberships, he was a well-known collector of Lincolniana and in 1957 presented his extensive collection to Georgetown University. He was an active civic leader and served with distinction on many local civic and service organizations. Donations may be made to the Vincentian Fathers of Springfield.

Arthur Nelson Ball, M.D.

Died July 10, 1976 at age 94 at his home. He was a graduate of the University of Maryland and the University of Pennsylvania Medical School (1911). He joined the staff of the Boston Psychopathic Hospital in 1912 and was promoted to Chief Executive Officer of that institution 11 years later. In 1914 he was named Assistant Superintendent of the State Colony where he served 5 years before being named Assistant to the Commissioner for Mental Disease of the State of Massachusetts. In 1931 he was appointed Superintendent of the Northampton State Hospital, a position he held for 17 years. He was considered an authority on legal mental health and did much to shape the court attitude as regards determining the mental state of convicted felons and those facing court hearings. He was a diplomat of the American Board of Psychiatry (1936) and was awarded a 50 year certificate by the American Psychiatric Society. He was long active in the New England Society of Psychiatry. He was also a member of the Jerusalem Lodge of Masons (Northampton) and active in several local service societies. Donations may be made to the Western Massachusetts Chapter of the American Heart Association.

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Francis I. Haggerty, M.D.

Died July 31, 1976 at age 80 in a local nursing home. He was a graduate of Holy Cross and Jefferson Medical College (1923). He interned at the Mercy Hospital, Springfield. He engaged in general practice and was a staff member at the Mercy Hospital for many years. He had received 50 year awards from the Massachusetts Medical Society and the Hampden District Medical Society in 1975. He was a member of Division 6 of the Ancient Order of Hibernians and the Knights of Columbus and was active in church affairs.

James L. Smead, M.D.

Died September 8, 1976 at age 76 in the Franklin County Public Hospital. He was a graduate of Dartmouth College and Harvard Medical School (1924). After a two year internship at the Hartford Hospital, he entered the practice of surgery in Springfield in 1926. He served on the staff of the Springfield Hospital for many years including positions as President of the Medical Staff, Surgeon in Chief, and was appointed Director of Medical Education and Research in 1960. He was a diplomat of the American Board of Surgery (1950), and a member of the American College of Surgery and the New England Surgical Society. He was a past president of the Hampden County Medical Society and a member of many professional societies. He was active in the Naval Reserve up to the time of his death. He was a member of several local service organizations.

Jesse G. Hafer, Jr., M.D.

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NOTICE:

October 25, 1976

At the Executive Committee meeting held on Tuesday, October 19, 1976 an Ad Hoc Committee was approved to study the publication, The Hampden Hippocrat.

This committee is chaired by Dr. Howard N. Simpson and the members of the committee are: John Remsberg, M.D., Walton E. Stevens, M.D., Bernard Bloom, M.D., Joseph Greenspan, M.D., John C. Ayres, M.D.

The charge to this committee is as follows:

This committee shall consider the pro's and con's of setting up within HDMS a "Publications Committee" to act as a board of trustees with respect to the publication of the Hippocrat, concerning itself with Hippocrat personnel, its general activities during the year and its financial status, among other things, and to provide for any other publication needs of the society as they may be approved by the society from time to time. The recommendation of the study committee shall be made to the Executive Committee.

A meeting of this committee was held on Wednesday, November 8, 1976 at 7:30 P.M. in the offices of the medical society.

Items from AMA Newsletter

Volume 8, Number 32

The AMA Board of Trustees, at its meeting last week, approved a fiscal 1977 budget based on expected revenue of $57,770,000 and expected expenditures of $46,205,000. The anticipated favorable balance will enable the AMA to place $11,565,000 in reserve, a policy reaffirmed by the House of Delegates at the 1975 Annual Convention. Spending during the fiscal year, which will end Nov. 30, 1977, will be spread among the six missions of the AMA Plan as follows: Scientific Policy and Information, $15,547,000; Promote the Effective Delivery of Care, $3,360,000; Assure and Continue to Improve the Quality of Medical Care, $8,146,000; Represent the Medical Profession, $6,265,000; Strengthen Organized Medicine, $5,524,000; and Internal Support Service, $5,863,000. Scheduled for the contingency fund is $1,500,000.

Revenue for the Budget is expected to come largely from membership dues, $36,869,000, and advertising, $10,187,000. Other sources of revenue are estimated at $2,114,000, subscriptions; $2,638,000, royalties; $545,000, books and pamphlets; $2,366,000, grants, contracts and educational programs; and $3,051,000, investments and other income.

Students Considering a Career in medicine and high school student counselors may find a new AMA booklet of great benefit. *Helping Hands: Horizons Unlimited in Medicine* is the successor of an earlier AMA factbook entitled *Horizons Unlimited.* The new booklet describes opportunities available in the medical profession and provides information on choosing a college and college courses, applying to and entering medical school along with the cost of a medical education and financial aid available. Opportunities for minority students and women in medical school are also discussed. The cost of the booklet (OP 160) is 50¢ each for 1 to 100 copies; 45¢ each for 100-1,000 copies; and 40¢ each for 1,000 or more. Write Order Dept., AMA Headquarters.

The AMA-ERF Board also granted $19,000 to support the Fifth Western Hemisphere Nutrition Congress, Aug. 15-18, 1977, in Quebec. The AMA is the primary sponsor of the congress. The grant will help underwrite program costs not covered in the AMA budget.

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An Ad Hoc Committee on Services to Young Physicians was established by the Board of Trustees. The 11-member committee will ascertain the needs of young, practicing physicians and make recommendations for the modification of existing AMA activities and the creation of new services. The committee will make its final report to the Board in September, 1977. The members of the committees will be physicians who have been in private practice for not less than five nor more than ten years.

Responding to the Needs of Medical Students, the American Medical Association Education and Research Foundation guaranteed 2,864 loans for $3,940,700 during the first six months of 1976. In the first half of 1975, AMA-ERF guaranteed only 1,816 loans. The 57.7% increase is the result of rising tuition and decreased government support. The six-months figures this year have surpassed the amounts for the entire year of 1972, when 2,654 loans totaling $3,631,000 were guaranteed.

Four Student Research Forums were awarded grants totaling $32,209 by the AMA-ERF Board of Directors at their meeting last week. The forums are sponsored by the American Medical Student Assn., three medical schools, and the Western Student Medical Research Committee. The National Student Research Forum will be at the U. of Texas Medical Branch at Galveston in April, 1977. Regional forums will be at the U. of Miami School of Medicine, at the U. of Cincinnati College of Medicine, and in Carmel, Calif.

AMA Spending Next Year will again lean heavily toward scientific programs, with emphasis on continuing medical education activities and on providing physicians with scientific information. The missions titled "Scientific Policy and Information" and "Assure and Continue to Improve the Quality of Medical Care" account for 51.2% of the budget expenditures. The 1977 Budget contains $1,333,975 for new projects and $3,513,100 for increased emphasis on existing projects; however, $674,135 will be saved by discontinuing certain projects and $222,305 will be saved by decreasing the emphasis on other projects. Spending in 1977 will exceed the proposed spending for 1976 by $3,950,635. Without changes in 1976 programs, inflation alone would have accounted for a $3.3 million increase in 1977.

AMA Membership on July 31 was 162,432, a total which included 144,723 regular, full dues-paying members, 9,500 intern and resident members, and 8,209 medical student members.

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Paul to Timothy

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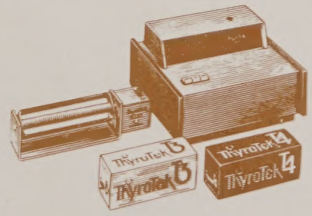

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